

THE IOWA ALLIANCE OF COMMUNITY MENTAL HEALTH CENTERS
RECOMMENDATIONS TO THE IOWA GENERAL ASSEMBLY
CONCERNING MENTAL HEALTH AND DISABILITY SERVICES SYSTEM REDESIGN

Senate File 2315

March 5, 2012

ABOUT THIS COMMENTARY #5

The Iowa Alliance of Community Mental Health Centers (the Alliance) represents 18 centers (see below) certified to serve as safety net providers for the majority of those with serious mental illnesses in our State. Alliance members primarily deliver child, adolescent, adult and family mental health services, and often substance abuse treatment, across most of Iowa's 99 counties that include well over two-thirds of Iowa's population.

This is the fifth in a series of Alliance commentaries addressing the specific issues confronting Iowa's public policy makers as they undertake to redesign a major component of this state's public and private health care delivery systems.

Commentary #4 recommended a number of changes to the nearly identical House Study Bill 646 and Senate Study Bill 3152 prior to their consideration in committee. However, these bills came out of those chamber's Human Resources Committees looking significantly different. The House version (now HF 2431) was changed little in committee. It came to the calendar this past week but has been re-referred to the House Appropriations Committee for additional consideration and likely amendment before returning to the calendar in the near future. A subsequent Alliance commentary will discuss those changes.

Blackhawk Grundy CMHC, Waterloo
Southern Iowa MHC, Ottumwa
Richmond Center, Ames
Vera French MHC, Davenport
Berryhill Center for MH, Ft. Dodge
Midwest Iowa MHC, Iowa City
Plains Area MHC, LeMars
North Iowa MHC, Mason City
Abbe Center, Cedar Rapids

Northeast Iowa Behavioral Health, Decorah
EyerlyBall CMHC, Des Moines
Center Associates, Marshalltown
Seasons Center for CMHC, Spencer
West Iowa CMHC, Denison
Orchard Place/Child Guidance Center CMHC, Des Moines
Community Health Centers of Southern Iowa, Leon
Waubonsie MHC, Clarinda
Hillcrest Family Services, Dubuque

Therefore, Commentary #5 addresses only SF 2315 because the Senate Human Resources Committee extensively amended its SSB 3152 before sending it to the Senate calendar on February 23rd. A number of recommendations from Commentary #4 were incorporated into that committee amendment as were changes requested by legislators, the department, and interested parties.

With the differences between the House and Senate on a number of key policy issues now more apparent it presents the advocate with a dilemma. Should the advocate now express a preference for one bill's language over the other or should the advocate's focus be chiefly on improving each chamber's approach to a common issue?

For the most part the Alliance has chosen the latter course on several key issues. We do so because, to their credit, the House and Senate floor managers for these bills have kept the door open to serious consideration of amendments coming from all quarters. The Senate has yet to debate and pass its version of Redesign. The House was precluded from amending its bill in committee because of the time constraints imposed by the legislative funnel schedule. However, it is likely to consider many of the same changes adopted by the Senate as HF 2431 moves through the Appropriations Committee and returns to the House calendar.

Therefore, there is much to be gained by continuing our work to improve both SF 2315 and HF 2431 prior to that floor debate. At some point the Alliance will make final advocacy choices between the House and Senate solutions to a particular issue but not now.

When the Alliance makes final decisions on these bills those decisions will be guided by its conclusions regarding answers to some fundamental questions. Will this legislation create for those in need of these health care and related services:

1. Greater accessibility to services delivered by providers held to higher levels of professional performance?
2. Stronger guidance to effective services through enhanced case management that includes accreditation, certification, and performance measurement programs?
3. Improved access to integrated behavioral health and primary care solutions?
4. Empowered voices for seeking adequate system funding?

SF 2315, an Act relating to the redesign of publicly funded mental health and disability services.

Our analysis in Commentary #5 continues the Alliance's consecutive page format used in prior commentaries. We have used section headings to facilitate way finding.

#1 SF 2315, Sec. 11, page 9, Regional Service System Management Plan

Plan Approvals - The bill requires regions to have their respective management plans approved for compliance with the requirements set forth in commission rules as well as those elements mandated elsewhere in the bill. The analysis that follows reflects the Alliance's continuing concerns over one of the most serious anomalies in the bill. However, for this Senate bill we have tightened our focus on issue.

The Alliance continues to study the regulatory oversight aspects of this proposed new system. Commentary #4 and a supplement reviewed this issue in depth. We recommended there that the Department of Human Services or its director, rather than the Mental Health and Developmental Services Commission (the commission), be delegated the bulk of the regulatory oversight functions implementing this legislation. We went so far as to recommend that commission become an advisory rather than a regulatory body. Several of our recommended changes were incorporated by committee amendment into SF 2315 and, in our view, significantly improved those lines of responsibility.

We continue to believe accountability for implementing this redesigned system should be placed with the department, its director, and thereby most directly on the office of governor. However, we have concluded this view is unlikely to be included in the Senate-passed version of this bill.

Therefore, we have narrowed our focus on this issue to policy making and policy implementation as it involves regional service system management plans. As discussed in detail below, **the Alliance supports the commission's rule making authority to define the elements of a regional plan (policy making) and the director's authority to approve those plans (policy implementation).** Granting this authority to the commission is consistent with the commission's policy-making responsibilities envisioned in Section 225C.5 of the Iowa Code. Granting the director plan approval authority is consistent with the department's central mission of overseeing the regional concept in its delivery of services.

An additional caveat concerns the requirement that the director, in exercising the authority to approve plans, must seek the commission's recommendations. We would respectfully disagree with what may appear at first to be an innocuous requirement. Given the commission's relatively infrequent meeting schedule and the likelihood that timeliness in approving annual plans and/or amendments could be very important to a region, we suggest the director be

required only to report all actions taken respecting plan approvals or disapprovals to the commission within some reasonable timeframe.

#1A Page 7, lines 17-18, provides that a plan shall address a three-year period and the director shall approve “the initial plan.” *[N.B. Page 7, lines 10-13 is a redundant, although slightly different, provision that includes the need for a commission recommendation to the director. Lines 10-13 should be deleted.]*

#1B Page 7, lines 24-26, provides that an annual update is subject to commission approval pursuant to a director’s recommendation. *[N.B. This allocation of authority should be reversed; it should be clarified whether the annual update requires adding another year to the plan so that a region always has a three-year plan. Implied but not stated.]*

#1C Page 7, lines 30-31, provides that any plan amendment is subject to commission approval pursuant to a director’s recommendation. *[N.B. This allocation of authority should be reversed.]*

#1D Page 10, lines 22-24, provides that the director’s plan approval is not a county budget certification. *[N.B. This provision would be consistent with giving the director approval authority over not only the initial plan but also annual updates, and amendments.]*

ACTION ITEM SUMMARY: Amend the bill to give the director approval authority over all plan submissions including the initial plan, the annual plan, and plan amendments (policy implementation) while retaining the commission’s rulemaking authority in determining what elements must be included in the plan (policy making).;

RATIONALE: As SF 2315 is currently written the director approves only the initial county plan and thereafter the commission approves any changes including annual plan updates and any intervening amendments. In effect, the director has no regulatory authority over this most important redesign implementation document. The Alliance considers this as its most serious concern with SF 2315.

Plan Elements - As noted above, the Alliance supports retaining the commission’s authority through rule making to designate the elements that must be included in a regional management plan. There are, however, several substantive and technical recommendations we submit for consideration. These are:

#1E Page 8, lines 16-19 and et seq., provides that the commission by rule shall determine the elements to be included in a plan. *[N.B. Page 7, lines 7-10 is a redundant provision that should be deleted; see also page 7, lines 32-35 through page 8, lines 1-8 as this provision would seem more appropriately placed as a sub-section under section 4 on*

page 8 at line 16; page 8, lines 9-15 would seem to be mis-placed here and perhaps it to should be re-written into section 4 below.]

#1F Page 8, line 16 through page 10, line 3, provides that the commission shall by rule determine the elements of a regional plan. It does not include a specific requirement that the plan include a budget. *[N.B. The element of a budget should be mandated by adding a specific sub-section requiring the plan to include a budget for the fiscal year plus a projected budget for all three years of the plan; the regional plan should include a yearly budget because fiscal oversight of the system is one of the key elements of the department's responsibilities. It is to the director that the legislature will look to for guidance and accountability; see also Page 9, lines 26-31 and Page 17, lines 15-17 which assume such a requirement is already in the bill but for which we can find no specific reference.]*

#1G Page 9, lines 32-35, provides that a region can, in its sole discretion, impose or grant, additional licensing, certification, or accreditation requirements over and above those required by the state. *[N.B. The region need only report "the procedures for implementing the requirements." This is an authority potentially fraught with favoritism and other pernicious behavior. It could impede efforts to improve the regulatory requirements over providers as described in Sec. 21, page 22. If this sub-section is not deleted, then a region exercising this authority should do so only with the department's approval and only through a plan amendment.]*

#2 SF 2315, Sec. 12. Page 10, Financial eligibility requirements.

The Alliance appreciates acceptance of several of its recommendations concerning co-pays and sliding fees schedules but one concern with this section remains.

#2A Page 11, lines 34-35, the list of assets eligible to be disregarded for eligibility purposes (see) is too restrictive. *[N.B. We recommend flexibility be given the commission within its rulemaking authority to expand that list.]*

#3 SF 2315, Sec. 13., Page 12, Diagnosis – functional assessment

#3A Page 12, lines 17-19, This provision states that the only way for a person to receive services (and the provider to be paid for providing the service) is for the person to have "during the preceding twelve-month period a diagnosable mental health, behavioral, or emotional disorder." *[We repeat the Alliance's comment from Commentary #4 -- What happens if a person presents, is given an assessment, and is found to not have one of those disorders? Does the person have to pay for the assessment? Should the provider be denied payment for conducting the assessment? That would be akin to allowing a person to refuse to pay a dentist if he/she has a checkup and the dentist finds no cavities? What if the cause of the symptoms presented is a physical ailment? Or what if a medical doctor has referred a person for assessment*

in order to exclude certain physical illness diagnoses that the doctor might otherwise consider treating? How does one become eligible for funding if the first appointment(s) at a CMHC is(are) to determine the diagnosis? It is ambiguous and unnecessary. ACTION ITEM – Delete this sentence or re-write the provision.]

#4 SF 2315, Sec. 14., Page 14, Regional core services.

As a general proposition, we are uncertain how some of these services can be provided within a region without some direct support and collaboration by one or more state agencies. We recognize the need for the qualifier “subject to the availability of funding” but ask the question of when, how, and by whom this availability or lack thereof is to be determined? This is another argument for giving the director oversight and approval of regional budgets and allocations because they will be driven by the department’s determination of the costs associated with each of these core services.

The Alliance notes transportation has been deleted from the list of core services included in previous bill drafts. We have not heard any rationale for doing so. As this is intended to be a complete listing of core services we recommend this service be considered further.

Assertive community treatment (ACT) is included as a core service.(Page 16, line 31) The Alliance may recommend deleting this item as inappropriate under this category of service but is preparing a separate issue brief to more thoroughly examine the ramifications of this item.

The term “evidence base” has come into vogue as a descriptor for an accountability tool intended to prevent use of untried or tested theories of diagnosis and treatment. We caution against its use in this context as being too restrictive. Consideration should be given to striking “evidence base”, page 17, lines 5 and 8 and inserting “promising practices,” “emerging practices,” or “evidence informed practices,” or other broader professionally recognized standard(s).

#5 SF 2315, Sec. 19., Page 18, Mental health and disability services workforce development workgroup.

The Alliance had asked that four “safety net providers” be specifically named to this work group including CMHCs, FQHCs, a hospital with a psych unit, and an MHI, all of which are named in the bill as mandatory providers in each region. However, noting yet another group was added by the committee amendment and that the list has become unwieldy, we recommend striking all but the state agency members and giving the department authority to name all other members except legislators who require legislative leader designation to serve.

#6 SF 2315, Sec. 20., Page 21, Regional service system—outcomes and performance measures committee.

The Alliance had asked that four “safety net providers” be specifically named to this work group including CMHCs, FQHCs, a hospital with a psych unit, and an MHI, all of which are named in the bill as mandatory providers in each region. However, this suggestion appears to have been misinterpreted to be a request for inclusion of a provider representative of the Iowa collaborative safety net provider network. (See page 21, lines 19-21. That was not the Alliance’s intention and therefore it asks that this reference be stricken or the providers referenced above be included.

#7 SF 2315, Sec. 25., Page 24, Mental health and disability services regions – criteria.

#7A Page 25, lines 4-8 gives the director authority to approve any region meeting this section’s requirements. However, it requires the director to share that authority with the commission for any waivers from the population or minimum county requirements. [N.B. *This is inappropriate because the commission is a policy making body while the director implements policy. This is an implementation function. Also, page 25, line 7 sets a legal standard requiring “convincing evidence” to exercise this joint authority. This is an undefined term. Our comments in Commentary #4 remain appropriate.*]

ACTION ITEM SUMMARY: Amend page 25, lines 4-5 by striking as follows: “director of human services, ~~with the approval of the state commission~~, may grant a waiver from the requirement relating”. See also, page 25, line 7 as follows: “population parameters if there is supporting ~~convincing~~ evidence that”.

#7B Page 27, lines 29-34, allows the department “with the concurrence of the state commission” to find a regional in substantial compliance with a significant list of implementation criteria. This list includes what is called “a regional service management transition plan.” [N.B. *This concurrence requirement is inconsistent with the director’s sole authority to approve regional plans requirements as recommended in the Alliance’s comments concerning plan approvals.*]

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